U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 02 September 2003

CASE NO. 2002-BLA-5486

In the Matter of

ISABELLE P. FRAMELI, Widow of
JOSEPH A. FRAMELI,
Claimant

v.

DIRECTOR, OFFICE OF WORKERS
COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Debra L. Henry, Esquire
For the Claimant

Brian J. Mohin, Esquire
For the Party-in-Interest

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER - DENYING BENEFITS

This proceeding arises from a claim for benefits filed by Isabelle P. Frameli, the surviving spouse of Joseph A. Frameli, a now deceased coal miner, under the Black Lung Benefits Act, 30 U.S.C. §901, *et seq.* Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations.[1]

[1] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised Part 718 regulations became effective on January 19, 2001. Since the current claim was filed on March 8, 2001 (DX 4), the new regulations are applicable (DX 25).

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was duly scheduled to be held on March 11, 2003 in Pittsburgh, Pennsylvania. Pursuant to Claimant's request, however, I issued an "Order Granting Motion to Close on Record and Cancellation of Hearing," dated March 4, 2003, in which I granted the request for a Decision on the Record; canceled the scheduled formal hearing; and, held the record open until March 11, 2003 for the submission of medical evidence and closing arguments. However, I subsequently granted Director's Motion for Enlargement of Time to File Closing Argument. Accordingly, the deadline for filing closing arguments was extended until April 11, 2003.

In summary, the documentary submissions received in evidence consists of Director's Exhibits 1 through 26 (DX 1-26) and Claimant's Exhibits 1 through 3 (CX 1-3). Furthermore, I have considered the closing arguments filed on behalf of Claimant and Director, OWCP, respectively.

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted, arguments made, and the testimony presented.[2] Where pertinent, I have made credibility determinations concerning the evidence.

Procedural History

On April 29, 1980, Joseph A. Frameli, a former coal miner, filed an application for black lung benefits under the Act (DX 1). Following a formal hearing before Administrative Law Judge George P. Morin on December 22, 1983, he issued a Decision and Order - Denying Benefits, dated August 17, 1984. In summary, Judge Morin analyzed the relevant medical evidence and concluded:

> On a record containing 10 readings and rereadings negative for pneumoconiosis, and 2 readings positive for pneumoconiosis, I find the weight of the evidence to be negative for pneumoconiosis.
>
> ...It is clear from the results reported above, which have been carefully checked against the qualifying values appearing in the regulations, that the Claimant has

[2] Although the formal hearing regarding the survivor's claim was canceled, I note that the miner had testified at a formal hearing held on December 22, 1983, in conjunction with one of his claims (DX 1).

> failed to demonstrate the presence of a totally disabling impairment through pulmonary function study results, and I so find.
>
> ...The results outlined in the above chart fail to establish that the Claimant is totally and permanently disabled by means of arterial blood gas study evidence.
>
> ...Weighing together the opinions expressed in the above four medical reports, I find that the preponderance of the medical opinion evidence does not favor the position that the Claimant is totally and permanently disabled due to a respiratory or pulmonary cause. One physician, Dr. Thomas E. Morgan, did so find. Drs. Strimlan and Wald, however, found that the Claimant was not so disabled, and their opinions seem to me to be based on the more credible objective medical evidence and the more rigorous clinical and diagnostic techniques. Dr. Troilo did not give an opinion on the degree of the Claimant's pulmonary- or respiratory-based disability. I therefore find that the Claimant has failed to meet any of the standards set forth in the regulations for showing pulmonary or respiratory impairment resulting in total disability.
>
> While the Claimant testified that his breathing condition limits his physical activities, his contention is not borne out by the medical evidence of record. On the basis of the entire record, I conclude that the Claimant does not have pneumoconiosis, either clinical or presumed. He is not totally disabled due to pneumoconiosis.
>
> ...The Claimant is not entitled to benefits under the Act.

(DX 1, ALJ Morin Decision and Order).

Following the miner's *pro se* appeal, the Benefits Review Board issued a Decision and Order, dated March 18, 1987, in which Judge Morin's Decision and Order denying benefits was affirmed (DX 1, BRB Decision and Order). Since the miner did not file a further appeal nor take any additional action in pursuit of the foregoing claim, it is deemed finally denied and administratively closed.

On or about December 9, 1988, Mr. Frameli filed a second application for black lung benefits under the Act (DX 2). In a "Proposed Decision and Order of No material Change in Condition and Denial of Benefits," dated June 8, 1989, the District Director (formerly known as Deputy Commissioner) determined that the miner had failed to establish a material change in condition, and he was not entitled to benefits. In making that determination, the District Director listed various additional medical data which he considered including x-ray, pulmonary function studies, and arterial blood gas results, dated December 30, 1988, and a physical conducted by Dr. Corrado on March 7, 1989. Since the miner did not appeal nor take any action in response to the

denial, this claim is also deemed finally denied and administratively closed (DX 2).[3]

On February 21, 2000, Joseph A. Frameli passed away (DX 10). On March 8, 2001, the Claimant, Isabelle P. Frameli, filed the current application for black lung benefits under the Act, as his surviving spouse (DX 1). This claim was denied by the District Director's office on November 29, 2001 (DX 18) and March 12, 2002 (DX 22), respectively. In summary, the District Director found that the miner had engaged in coal mine employment for 35 years during the period from May 1, 1941 to February 1, 1980; and, the miner had contracted pneumoconiosis which arose, at least in part, from his coal mine work. However, the District Director denied benefits on the grounds that the evidence does not show that death was due to pneumoconiosis (DX 22).

Following Claimant's request for a formal hearing (DX 19), this matter was referred to the Office of Administrative Law Judges on or about September 16, 2002 for *de novo* adjudication (DX 23). I was assigned the case on November 15, 2002. As stated above, pursuant to Claimant's request, the formal hearing was canceled and this matter is decided on the record, which was closed on April 11, 2003.

Issues

The only contested issue is whether the miner's death was due to pneumoconiosis, as defined in the Act and applicable regulations (DX 23; *See also* Closing Arguments of the respective parties).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background and Employment History

A. Coal Miner

The record clearly establishes that former miner, Joseph A. Frameli, engaged in coal mine employment for at least 35 years ending in 1980 (DX 6,7,8). Furthermore, I find that any discrepancy in the exact number of years of coal mine employment is inconsequential for the

[3] Under cover letters, dated July 18, 1989 and July, 25, 1989, various additional medical data were submitted on behalf of the previously designated responsible operator. However, counsel for the employer specified that he was not seeking further action or consideration of such evidence by the District Director; instead, he was simply submitting it for inclusion in the file, in case the miner pursued the matter, and the miner's case were heard by an administrative law judge (DX 2).

purpose of rendering a decision herein.[4]

B. Date of Filing

Claimant, Isabelle P. Frameli, filed her claim for survivor's benefits under the Act, on March 8, 2001 (DX 1). The Director has stipulated, and I find, that the claim was timely filed (DX 23).

D. Dependents

Claimant, Isabelle P. Frameli, has no dependents for purposes of augmentation of benefits under the Act (DX 4).

E. Personal Background and Other Lay Evidence

The former miner, Joseph A. Frameli, was born on January 27, 1922. He married Isabelle P. Frameli (nee Battaglini) on February 14, 1955. They remained married until the miner's death on February 21, 2000 (DX 4,9,10).

On her application for survivor's benefits, Clamant set forth the following description of the miner's disability:

> Joseph A. Frameli had to retire from the Clyde Mine in 2-29-1980 at the age of 58 because he had difficulty breathing. He had chronic obstructive pulmonary disease, hypertension, congestive heart failure, angina, progressive shortness of breath with chest tightness, organic brain syndrome with small strokes, hypoxemia, and dyspnea. He was limited to (sic) what he could do. He couldn't do much physical activity because his chest would hurt and he couldn't breathe very well.

(DX 4).

Medical Evidence

The case file includes various chest x-ray interpretations, pulmonary function studies, arterial blood gas tests, and medical opinions from the living miner's claim, which is part of the record (DX 1,2). As stated above, the evidence presented in the miner's case did not establish the existence of pneumoconiosis or total disability by any respiratory or pulmonary impairment, as found by Judge Morin in his Decision and Order - Denying Benefits, dated August 17, 1984, and,

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[4] On Claiant's application form, she claimed that her husband had worked in or around coal mines for 39 years (DX 4). This is consistent with the miner's initial application, dated April 29, 1980 (DX 1). However, on the miner's second application, dated December 9, 1988, he only alleged 35 years of such employment (DX 2).

affirmed in the Board's Decision and Order, dated March 18, 1987. Furthermore, as found by the District Director, on June 8, 1989, in conjunction with the miner's second claim, additional medical data failed to establish a material change in conditions. However, the District Director now concedes the presence of pneumoconiosis and its causal relationship to Mr. Frameli's coal mine employment (DX 22,23). Furthermore, the nonqualifying clinical test results obtained on pulmonary function studies and arterial blood gas studies many years prior to the miner's death does not preclude the possibility that Mr. Frameli's death, in 2000, was not caused or substantially related to pneumoconiosis. Moreover, none of the physicians opinions in the miner's claim addressed the "death due to pneumoconiosis" issue.

Since the crux of the survivor's claim is the "death due to pneumoconiosis" issue, I find that the most relevant medical evidence is as follows: the more recent medical evidence, including hospital records, particularly shortly before his death (DX 12,13); the miner's death certificate (DX 10); the autopsy report (DX 11); and, the medical opinions of Drs. McMonagle (DX 14), Perper (15,26), and Green (CX 1,2).

The case file reveals that the miner was hospitalized on several occasions in the years immediately preceding his death (DX 12,13). The Uniontown Hospital Discharge Summary, dated November 1, 1996, indicates that the miner was hospitalized from October 25, 1996 until November 1, 1996 (DX 12). The discharge diagnoses were as follows: Pneumonia, Chronic Obstructive Pulmonary Disease, Acute Confusional State, Early Alzheimer's Disease, Hypertension, and Facial Pain (DX 12). In pertinent part, the Discharge Summary reveals that the miner had various problems upon admission, including shortness of breath and coughing; physical examination of the lungs indicated "scattered rhonchi and wheezing;" chest x-ray was "consistent with pneumoconiosis;" however, repeat chest x-ray prior to discharge "was improving and his infiltrate almost entirely cleared." In fact, "chest x-ray prior to discharge was actually normal." (DX 12).

The miner was later treated at Uniontown Hospital during the period from December 31, 1998 until his discharge on January 6, 1999 (DX 12). The attending physician, Dr. McMonagle, consulted with Dr. James R. Powell, a pulmonologist, regarding the miner's hypoxemia. In his report, dated January 3, 1999, Dr. Powell set forth the following history of present illness:

> This 76 year old white male, retired coal miner of over 25 years, remote smoker, was admitted on 12/31/98 with dyspnea. He was treated with diuretics and supplemental oxygen because of suspected congestive heart failure. Accupril and Norvasc have been prescribed for hypertension. Clinically the patient claims to have diuresed quite well and edema, dyspnea and chest pain on admission have resolved. He was hypoxic with a pO2 of only 55 on room air on admission. Chest x-ray on admission have reports "no definite acute abnormality," however to my review congestive heart failure with cardiomegaly, pulmonary edema and small pleural effusion are present consistent with congestive heart failure. Pulmonary consultation has been requested to evaluate hypoxemia and dyspnea.

(DX 12). Physical findings revealed bibasilar rales. Chest x-ray findings were as set forth above. Moreover, Dr. Powell specifically noted: "I do not see any definite radiographic evidence for pneumoconiosis." In addition, Dr. Powell stated that, although the miner was hypoxemic on admission with a pO2 of 55, "[b]lood gas today (*i.e.*, 1/3/99) revealed pO2 in the 80s." Furthermore, Dr. Powell stated that "will check PFTs."(DX 12).

On January 4, 1999, Mr. Frameli performed a pulmonary function study, which yielded nonqualifying results. Moreover, on the "Pulmonary Function Test Interpretation" report, dated January 7, 1999, Dr. Powell concluded:

> SUMMARY: In spite of suboptimal effort the current study is essentially normal except for reductions in peak flow rate and maximum voluntary ventilation measurements. Recent administration 14 hours ago of Serevent may have improved baseline pulmonary function and thus clinical correlation is advised.

(DX 12).

On January 5, 1999, a Consultation Report, dated January 5, 1999, was issued by Dr. Joseph S. Briskie, D.O., regarding the miner's congestive heart failure and progressive shortness of breath (DX 12). In summary, Dr. Briskie set forth the following Impression and Conclusion:

> IMPRESSION: New onset congestive heart failure
> Rule out underlying coronary artery insufficiency
> Hypertension
> Exogenous obesity
> Probable hyperlipidemia
> Chronic obstructive pulmonary disease

(DX 12).

The Uniontown Hospital Consultation Report, dated October 27, 1999, authored by Dr. Briskie, reveals that he was consulted because of Mr. Frameli's congestive heart failure with complaints of chest pain and shortness of breath (DX 12). Chest examination revealed "diminished intercostal retractions with diminished breath sounds in the bases bilaterally." Chest x-ray revealed congestive heart failure. Numerous abnormalities were also seen on echocardiogram and Persantine imaging study. In summary, Dr. Briskie stated:

> IMPRESSION: 1. Acute onset of chest pain and shortness of breath with congestive heart failure.
> 2. History of diastolic dysfunction with interior lateral wall ischemic showing up on his imaging study. Certainly, rule out coronary insufficiency.
> 3. History of hypertension

4. COPD
5. Hyperlipidemia

CONCLUSION: At this time I have added low dose Zaroxolyn therapy to his regimen. I have changed him to short acting ACE inhibitors, Vasotec twice a day for heart failure and blood pressure control. I will repeat echocardiogram. I have also suggested that he undergo left and right heart catheterization procedure to re-stratify because of his recurrent symptoms at this time. I will follow him and monitor him closely while he is here in the hospital and I will discuss further with you.

(DX 12).

The Uniontown Hospital Discharge Summary (10/25/99-10/28/99) dictated by Dr. McMonagle on November 25, 1999 (DX 12), sets forth the following diagnoses:

1. Congestive heart failure.
2. Angina pectoris.
3. Atherosclerotic heart disease.
4. Hypertension.
5. Chronic obstructive pulmonary disease.
6. Coal worker's pneumoconiosis.

The discharge summary indicates that Mr. Frameli "has had cardiopulmonary disease, developed progressive shortness of breath with vague tightness with orthopnea and PND." Exam of the lungs revealed "Few basilar rales." Chest x-ray revealed "cardiomegaly; no acute pathology." Electrocardiogram showed diffuse non-specific ST/T wave changes; left bundle branch block; left ventricular hypertrophy; ejection fraction 55%; otherwise, essentially unremarkable. The patient was admitted, observed, treated with nitrates, diuretics, anti-anginal compounds. The patient did improve. He was seen by Dr. Briskie. Cardiac catheterization was recommended (DX 12).

Following catheterization, on November 1, 1999, Dr. Briskie found significant coronary disease and recommended that the miner "undergo coronary artery bypass grafting surgery as well as evaluation to undergo aortic valve replacement." (DX 12).

During the period from November 1, 1999 until December 3, 1999, Mr. Frameli was treated at the Mercy Hospital of Pittsburgh (DX 12). The Discharge Summary by Dr. George F. Woelfel lists the admitting and discharge diagnoses as follows: "Coronary artery disease and aortic valve disease." It also indicates that, on November 5, 1999, the miner underwent "coronary artery bypass graft times four and aortic replacement with a 23 mm pericardial biprosthesis." (DX 12).

The Allegheny University Medical Centers' History and Physical Examination report issued by Dr. David Celko states that the miner was admitted on December 17, 1999 (DX 13). The History of Present Illness is described as follows: Mr. Frameli is 77-years-of-age and is ventilatory dependent and resides at Greenery Rehabilitation Center. He was found unresponsive and hypotensive. He was transported to ER at Canonsburg General Hospital where he was found to be septic and had profound fluid and electrolyte abnormalities. At this point he is presently on the ventilator and being treated through a multi disciplinary approach. No additional information is available." (DX 13). The following was listed under Past Medical History: "History of MRSA, CAD. Post CABGs, tracheostomy." Physical finding of examination of lungs revealed: "Scattered rhonchi. Healed sternotomy incisional scar. Diminished breath sounds bilaterally." Laboratory data included: "total CO2 28." In conclusion, the following "Impression" and Plan" were noted:

> IMPRESSION:
> 1. CAD, status post CABG
> 2. Ventilator dependence.
> 3. Sepsis.
> 4. Fluid and electrolyte abnormalities, including hyponastremia and prerenal azotemia.
> 5. Hyperglycemia, cannot exclude nonketonic hyperosmolar state.
> 6. MRSA historically.
>
> PLAN: At this point, will fluid resuscitate patient. Have renal input, as well as Endocronologic standpoint. Further recommendations to follow.
>
> HE IS A FULL CODE BY ADVANCED DIRECTIVE.

(DX 13).

The Canonsburg General Hospital Discharge Summary, issued by Dr. Celko, states that the miner was hospitalized from December 17, 1999 until he was discharged on December 21, 1999 (DX 13). The discharge diagnoses were as follows:

1. Sepsis.
2. Uncontrolled diabetes mellitus.
3. Electrolytes imbalance.
4. Dehydration.
5. Acute renal failure.
6. Ventilator dependence.
7. Anemia.
8. ASHD.
9. Post CABGs Surgery.

(DX 13). The clinical tests included blood gases which revealed the following values: PCO2-28,

PO2-91 (DX 13). Finally, the "Hospital Course" was described as follows:

> The patient was admitted with sepsis, fluid and electrolyte imbalance was stabilized. He was subsequently discharged back to The Greenery on a comprehensive regimen once resolution of his acute renal failure and electrolyte problems resolved. Endoscopy revealed NG suction marks without any other lesions. He will be followed regularly with H&H at The Greenery. His long-term prognosis is guarded.

(DX 13).

The miner's death certificate, which was signed by Dr. Len Barats, states that Mr. Frameli died on February 21, 2000, at age 78 (DX 10). The immediate cause of death was reported as "Pneumonia," which reportedly manifest itself "Days" before the miner's death. The death certificate also states that the miner's pneumonia was due to anthracosis, which in turn, was due to coronary artery disease. The miner's reported anthracosis and coronary artery disease reportedly began "years" before the miner's death (DX 10). Although the term "anthracosis" falls within the definition of "Clinical Pneumoconiosis" as set forth in §718.201(a)(1), I find the death certificate is neither well-reasoned nor well-documented. Although it indicates that an autopsy was performed, it does not specify whether the autopsy findings were completed prior to completion of the cause of death section (DX 10). Furthermore, there is no indication that Dr. Barats treated the miner or knew his condition prior to death. Moreover, Dr. Barats provided no explanation or bases for the findings he listed in the death certificate. Therefore, the death certificate is accorded no weight.

Dr. Katherine M. Jasnosz, a pathologist at Allegheny University Hospitals, and Dr. Margaret Misztal, a Resident, co-authored the autopsy report, which was performed on February 22, 2000 (DX 11). The autopsy report includes findings on external examination, internal examination, and a microscopic description of the Respiratory System, as follows:

> Sections of the lungs show diffuse organizing bronchopneumonia with vascular congestion, mild pulmonary edema and local alveolar hemorrhage. There are also scattered anthrasilicotic nodules ranging in size between 0.2 and 0.3 cm. (Largest measure: 0.4 cm) and diffuse mild emphysema.

(DX 11).

Based upon the foregoing, Drs. Jasnosz and Misztal set forth the following final anatomic diagnoses:

I. Organizing bronchopneumonia, bilateral
   A. Mild pulmonary edema
   B. Diffuse mild emphysema

II. Simple coal worker's pneumoconiosis

(DX 11). In addition, Drs. Jasnosz and Misztal set forth the following "Final Summary" and "Clinical Summary:"

FINAL SUMMARY

> The patient was a 78-year-old-white male who was found unresponsive, hypotensive and with apneic episodes. He was a resident of Greenway Rehabilitation Center. His past medical history included coronary artery disease, chronic obstructive pulmonary disease, coalworker's pneumoconiosis and other conditions. After admission to Catonsburg General Hospital and (sic) he was diagnosed with pneumonia, dehydration, and possible sepsis and subsequently intubated. In the setting of progressive respiratory failure, a "do not resuscitate" order was made and the patient was pronounced dead on February 21, 2000 at 7:37 p.m.
>
> The main findings at autopsy which was limited to the lungs, were bronchopneumonia, mild pulmonary edema, emphysema and scattered anthrasilicotic micronodules, consistent with simple coal worker's pneumoconiosis.
>
> There are two forms of coal worker's pneumoconiosis (CWP), simple and complicated. Simple CWP, which occurs only after many years of underground mine work, is a relatively benign condition characterized by small focal aggregations of coal dust laden macrophages and coal macules within lung parenchyma. These areas of focal black pigmentations are scattered through the lung fields and range up to 55 mm but are usually 1 to 2 mm in diameter. The airspaces in and about the macules may be enlarged but the intervening parenchyma is unaffected. Complicated CWP also referred to as progressive massive fibrosis (PMF), is characterized by large, sometimes massive black scars that exceed 2 cm in diameter and sometimes achieve dimensions of 5 to 10 cm. When attached to the pleura, they may cause retraction and thickening of the pleura. The surrounding airspaces are usually markedly distended and appear honeycombed and the nodes of drainage are blackened, fibrotic and often interadherent.

(DX 11). (Citation to Medical Reference omitted).

CLINICAL SUMMARY

> The patient was a 78-year-old-white male who was found unresponsive, hypotensive and with apneic episodes. He was a resident of Greenway

> Rehabilitation Center. His past medical history was significant for coronary artery disease, chronic obstructive pulmonary disease, hypertension, congestive heart failure, multiple CVAs and resultant organic brain syndrome, type II diabetes mellitus and coal worker's pneumoconiosis. In November 1999, he underwent quadruple coronary artery bypass grafting and aortic valve replacement with biprosthesis, which was complicated by acute respiratory failure requiring (sic) pneumonitis. The patient was brought to Canonsburg General Hospital, and after evaluation was intubated for respiratory failure. He was also diagnosed with right lower lobe pneumonia, dehydration, possible sepsis and oral candidiasis. In the setting of progressive respiratory failure, a "do not resuscitate" order was made [and] the patient was pronounced dead on February 21, 2000 at 7:37 p.m.

(DX 11).

Dr. Carey L. McMonagle, who is Board-certified in Internal Medicine (DX 21), issued a two-page report, dated August 2, 2001 (DX 14). Dr. McMonagle stated that he had be one of the miner's treating physicians from February 16, 1995 until August 30, 1999; and, during that period the miner had 27 office visits, as well as multiple hospitalizations at Uniontown Hospital. Dr. McMonagle noted that the miner's diagnoses included: "chronic obstructive pulmonary disease, gastroesophageal reflux disease, peptic ulcer disease, hypertension, degenerative joint disease, peptic ulcer disease, degenerative joint disease, prostatic hypertrophy, trigeminal neuralgia, vertigo, likely some element of multi-infarct dementia and, as a terminal event, status post coronary artery bypass grafting with aortic valve replacement and congestive heart failure." (DX 14). Dr. McMonagle added: "However, the latter three - that is, the cardiac diagnoses - were only pre-terminal." (DX 14). Furthermore, Dr. McMonagle stated:

> In this period of time, he was treated primarily by myself for control of hypertension. When I initially saw him in 1995, he was referred by Dr. Stokes, a gastroenterologist, who was treating him for peptic ulcer disease. He was recorded by myself during office visits as being short of breath and hypertensive requiring therapy for these illnesses. Later in the course of his medical history, that is – in 1998 – he subsequently was hospitalized at the Uniontown Hospital for progressive congestive heart failure with aortic insufficiency. He underwent bypass grafting at Mercy Hospital in Pittsburgh with aortic valve replacement. This was pre-terminal treatment at Mercy Hospital in Pittsburgh. Subsequently, he could not be weaned from the ventilator and died postoperatively after a long complicated illness.

(DX 14).

Dr. McMonagle noted that he also had the opportunity to review records regarding the miner's medical condition dating back to the 1980's. He stated that Mr. Frameli "was forced to retire from his former employment as a coal worker due to shortness of breath...[which]...was

documented by four physicians who had seen him including his primary treating physician during the early 1980's." Dr. McMonagle also noted that the miner "had only smoked minimally not for a prolonged period." Following a further discussion of the miner's medical records, Dr. McMonagle concluded:

> After review of my own records and the records including from various treatment facilities prior to death – that is, the rehabilitative hospital, Canonsburg Hospital and Mercy Hospital, the treating physicians at Centerville Clinic and prior records – it is my medical feeling that the patient did indeed have chronic obstructive pulmonary disease and the cause of this would be coal worker's pneumoconiosis. The coal worker's pneumoconiosis, in my medical opinion, would be a substantial contributing cause of the patient's death.
>
> I do believe that the patient's chronic lung disease – that is, secondary to coal worker's pneumoconiosis– made him weaning from the ventilator much more difficult than it would have been and thus exposed him to complications on the ventilator and subsequent death. In addition, during the period of time from which he had to retire in the early 1980's until his death in the late 1990's, his physical activity was greatly limited also jeopardizing his overall health. It is well recognized that persons who are able to maintain higher levels of physical activity have a much better overall prognosis. Again, it is recognized that he did have congestive heart failure but this was only more of a pre-terminal event occurring only relatively shortly prior to his cardiac surgery and subsequent death. The echocardiograms and other clinical evaluation by physicians who had seen him prior to the bypass surgery had not indicated congestive heart failure.
>
> Indeed during the 1980's and 1990's at the Centerville Clinic, the patient was treated by a variety of physicians with bronchodilators such as "Albuterol, Atrovent, Azmacort " and others and also Theophylline compounds in an attempt to help his breathing secondary to his lung disease. I do believe the clinical diagnosis fits best with chronic obstructive pulmonary disease secondary to coal worker's pneumoconiosis as a substantial contributing factor to the patient's death.

(DX 14).

Dr. Joshua A. Perper has been Board-certified in Anatomical and Surgical Pathology, as well as Forensic Pathology since 1972; he had previously obtained a law degree in 1966; and, he has an impressive curriculum vitae (DX 16). On August 30, 2001, Dr. Perper issued a lengthy report (DX 15), in which he provided a detailed summary of the available medical data. Furthermore, Dr. Perper provided his own findings on microscopic examination of the autopsy tissue, and answered various questions. In summary, Dr. Perper concluded:

> 1. Mr. Frameli had evidence of mild coal workers' pneumoconiosis with rare

pneumoconiotic lesions.

2. Mr. Ray, a coal miner with a long standing occupational exposure of more than 25 years to coal mine dust, as a miner, developed coal workers' pneumoconiosis as a result of his occupational exposure to coal mine dust.

3. There is insufficient evidence to support a conclusion that coal workers' pneumoconiosis, was a substantial contributing cause or a hastening factor in Mr. Frameli's death.

4. Mr. Frameli died of acute and organizing bronchopneumonia complicating coronary heart disease and centrilobular [emphysema].

(DX 15).

Dr. Francis H.Y. Green has been Board-certified in Anatomic Pathology since 1984, and also has an impressive curriculum vitae (CX 3). In his report, dated November 12, 2002, Dr. Green reviewed available medical records. In addition, Dr. Green provided his own findings on microscopic examination of the autopsy slides, and answered various questions. In summary, Dr. Green set forth the following diagnoses:

1. Simple coal worker's pneumoconiosis, comprising macules, micronodules, and silicotic nodules, moderate severe.

2. Silicotic nodules in the tracheo-bronchial lymph nodes.

3. Focal, centriacinar and scar emphysema, mild to moderate severity.

4. Acute and resolving pneumonia.

5. Fibrinous pleuritis.

6. Pulmonary congestion and edema.

7. Accumulations of foamy macrophages.

(CX 1).

Following a further discussion of the miner's medical history, Dr. Green opined:

...Mr. Frameli died in acute respiratory failure due to pneumonia following cardiac surgery. Cardiovascular disease, in combination with COPD and pneumoconiosis were the underlying diseases leading to death. It is opinion that the pneumoconiosis contributed to his death through the following mechanisms. The

> medical pneumoconiosis (macules, nodules and silicosis) would have caused direct narrowing of pulmonary blood vessels, thus raising the pulmonary arterial pressure. The increased pressure would have put an increased workload on the right ventricle contributing to cardiac failure. This effect would be compounded by the dust-induced emphysema. Localized hypoxia as a result of emphysema results in constriction of pulmonary blood vessels and further increases pulmonary vascular resistance. Thus, the dust-induced COPD and the pneumoconiosis would cause an additional strain on a heart already compromised by ischemic heart disease increasing the workload of the heart and reducing the supply of oxygen to the heart muscle. COPD also predisposes to the development of bronchopneumonia, the immediate cause of death. Acute pneumonia would further reduce the blood oxygen levels leading to a combination of cardiac and respiratory failure. For these reasons, it is my opinion, to a reasonable degree of medical certainty, that pneumoconiosis including the dust-induced emphysema directly contributed to the proximate and underlying events that led to death.

(CX 1).

In a supplemental report, dated January 24, 2003, Dr. Perper reviewed his own report, dated August 30, 2001, as well as Dr. Green's report, dated November 12, 2002 (DX 26). In summary, Dr. Perper set forth numerous criticisms of Dr. Green's report, which are highlighted below:

(1) Dr. Green's microscopic observations of "numerous coal dust micronodules measuring up to 5 mm" are "totally imaginary," and are contrary to the findings of the prosector and Dr. Perper. The pneumoconiotic lesions were "very sparse and only a conglomerate of micronodules reached 3.5 - 4 mm." Accordingly, "Dr. Green's diagnosis of moderately severe simple coal worker's pneumoconiosis is incorrect and unjustified."

(2) Dr. Green's differentiation between "focal emphysema" associated with macules and "scar emphysema" associated with nodules, is contrary to the medical literature and medical experience.

(3) Dr. Green's diagnosis and rating of the miner's emphysema as "mild to moderate" is unwarranted. As found by the prosector and Dr. Perper, the emphysema was "mild."

(4) "Dr. Green's assumption that pneumoconiosis contributed to the patient's death by causing 'direct narrowing of pulmonary blood vessels thus raising the pulmonary arterial pressure' is totally speculative. Pulmonary hypertension when present is marked by sclerosis of small intra-pulmonary blood vessels with thickening fibrosis of their walls and with luminal narrowing. No such changes were present in the above deceased' lungs, and even Dr. Green himself could not bring himself to describe such finding."

In summary, Dr. Perper stated:

> In conclusion after reviewing Dr. Green's report of November 12, 2002 and my previous report of August 30, 2001, it is my professional opinion within a reasonable degree of medical certainty that there are no reasonable grounds to prompt a change in my opinion expressed in my report. As discussed above this conclusion is based on the facts that:
>
> 1. Dr. Green's report relies on unrealistic and unjustified exaggeration of the severity of Mr. Frameli's microscopic pulmonary findings of pneumoconiosis and emphysema.
>
> 2. Dr. Green's report invokes unfounded speculations of narrowing (contraction) of intra-pulmonary vessels in attempting to connect the patient's pneumoconiosis and emphysema to his death.
>
> My professional opinion stands as initially stated in my above report that simple coal workers pneumoconiosis and pulmonary emphysema were to mild to have contributed to the death or hastened the death of Mr. Frameli.

(DX 26).

In a supplemental report, dated February 14, 2003, Dr. Green reviewed Dr. Perper's supplemental report, dated January 24, 2003, and sought to address the comments and criticisms cited therein (CX 2). The highlights of Dr. Green's responses are as follows:

> 1. His own microscopic observations were more detailed and objective than those of Dr. Perper. Dr. Green cited references in his own report to various macules and lesions, based upon which he had stated: "The overall profusion of the simple pneumoconiosis is moderate to severe."
>
> 2. It was unwarranted for Dr. Perper to describe Dr. Green's findings of numerous coal dust micronodules measuring up to 5 mm as "totally imaginary," in view of Dr. Perper's own finding of "...micronodules [which] reached 3.5 – 4 mm."
>
> 3. His finding of "moderately severe simple coal worker's pneumoconiosis" is consistent with appropriate grading systems. Therefore, Dr. Perper was wrong to describe it as "incorrect and unjustified."
>
> 4. Dr. Perper's position regarding the differentiation between focal emphysema associated with macules and scar emphysema associated with nodules is undocumented and inconsistent with medical literature.
>
> 5. It was inappropriate for Dr. Perper to describe Dr. Green's finding of "mild to

moderate" emphysema as "clearly unwarranted," since there is hardly a difference between Dr. Green's assessment and the findings by Dr. Perper and the prosector of "mild" emphysema.

6. Dr. Perper's opinion that "Dr. Green's report invokes unfounded speculations of narrowing (contraction) of intra-pulmonary vessels in attempting to connect the pneumoconiosis and emphysema to his death" is erroneous, since it is well established in medical literature that there is a relationship between hypoxia and pulmonary blood flow.

(CX 2). In conclusion, Dr. Green stated:

> Dr. Perper ends his report by saying that his opinions are not altered by reading my report. I will also state that my opinions as set out in my original report, dated November 12, 2002, are not altered by Dr. Perper's critique and stand as originally expressed. I do welcome the opportunity to clarify my opinions.

(CX 2).

Discussion and Applicable Law

As set forth above, the Director stipulated, and I find, that Mr. Frameli had simple pneumoconiosis, which arose from his approximately 35 years of coal mine employment. However, in order to be eligible for benefits, Claimant must also establish that the miner's death was due to pneumoconiosis, as provided in the Act and applicable regulations.

Death due to Pneumoconiosis

Since the claim was filed after January 1, 1982, the issue of death due to pneumoconiosis is governed by § 718.205(c), as amended, which states, in pertinent part:

> For the purpose of adjudicating survivor's claims filed on or after January 1, 1982, death will be considered to be due to pneumoconiosis if any of the following criteria is met:
>
> (1) Where competent medical evidence establishes that pneumoconiosis was the cause of the miner's death, or
>
> (2) Where pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or where the death was caused by complications of pneumoconiosis, or
>
> (3) Where the presumption set forth at § 718.304 is applicable.

(4) However, survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death.

(5) Pneumoconiosis is a "substantially contributing cause" of a miner's death if it hastens the miner's death.

20 C.F.R. § 718.205(c).

As outlined above, there is no medical evidence which establishes that pneumoconiosis was the immediate and/or primary cause of the miner's death. Furthermore, there is no credible evidence of complicated pneumoconiosis. Therefore, I find that Claimant has clearly failed to establish "death due to pneumoconiosis" under §718.205(c)(1) and (3). Accordingly, the crux of this case is whether or not the miner's found simple coal worker's pneumoconiosis substantially contributed and/or hastened the miner's death. *See* 20 C.F.R. §718.205(c)(2), (4), (5).

As stated above, no weight is accorded to the death certificate, which is undocumented and unreasoned. However, the record also includes the autopsy report (DX 11), as well as the medical opinions of Drs. McMonagle (DX 14), Perper (15,26), and Green (CX 1,2), which also address the cause of death.

As outlined above, the autopsy report was co-authored by Dr. Jasnosz, a pathologist at Allegheny University Hospitals, and Dr. Misztal, a Resident (DX 11). The autopsy report lists simple coal worker's pneumoconiosis among the diagnosed conditions. Furthermore, chronic obstructive pulmonary disease and coal worker's pneumoconiosis are included among various conditions listed in the "Final Summary" and "Clinical Summary" portions of the autopsy report, as part of the miner's past medical history. However, the autopsy report does not specify that the foregoing conditions caused, substantially contributed to, or hastened the miner's death. While the report does not expressly preclude such a relationship, I note that the microscopic findings of "scattered anthrasilicotic nodules" which primarily ranged in size between 0.2 and 0.3 cm and the finding of only "mild emphysema" are more consistent with the pathology findings of Dr. Perper than those of Dr. Green. Moreover, as summarized above, the concluding portion of the "Clinical Summary" states:

In November 1999, he underwent quadruple coronary artery bypass grafting and aortic valve replacement with biprosthesis, which was complicated by acute respiratory failure requiring (sic) pneumonitis. The patient was brought to Canonsburg General Hospital, and after evaluation was intubated for respiratory failure. He was also diagnosed with right lower lobe pneumonia, dehydration, possible sepsis and oral candidiasis. In the setting of progressive respiratory failure, a "do not resuscitate" order was made [and] the patient was pronounced dead on February 21, 2000 at 7:37 p.m.

(DX 11).

Of the remaining physicians listed above, Drs. McMonagle and Green stated that the miner's coal worker's pneumoconiosis was a substantially contributing factor in and/or hastened the miner's death. In contrast, Dr. Perper found that the miner's mild simple coal worker's pneumoconiosis did not cause, substantially contribute, or hasten the miner's death.

Since Dr. McMonagle was one of the miner's treating physicians, I must consider the following factors in weighing his opinion: nature of relationship; duration of relationship; frequency of treatment; and, extent of treatment. 20 C.F.R. §718.104(d).

As set forth in Dr. McMonagle's report, dated August 2, 2001, the miner had 27 office visits and was hospitalized on various occasions during the period in which Dr. McMonagle treated him; namely, February 16, 1995 until August 30, 1999. However, Dr. McMonagle acknowledged that he primarily treated the miner for hypertension. Furthermore, he did not treat Mr. Frameli for almost six months prior to his death (*i.e.*, August 31, 1999 - February 21, 2000).

In summary, the length of Dr. McMonagle's relationship was approximately 4 ½ years, and the frequency of visits was fairly extensive. However, Dr. McMonagle acknowledged that he primarily treated the miner for non-respiratory conditions. Furthermore, Dr. McMonagle did not treat the miner for almost six months immediately prior to the miner's death. Accordingly, I find that Dr. McMonagle did not have a superior understanding of the miner's condition, particularly as to the "death due to pneumoconiosis" issue. Moreover, Dr. McMonagle stated, in pertinet part:

> [D]uring the 1980's and 1990's at the Centerville Clinic, the patient was treated by a variety of physicians with bronchodilators such as "Albuterol, Atrovent, Azmacort " and others and also Theophylline compounds in an attempt to help his breathing secondary to his lung disease. I do believe the clinical diagnosis fits best with chronic obstructive pulmonary disease secondary to coal worker's pneumoconiosis as a substantial contributing factor to the patient's death.

(DX 14). I find the foregoing conclusion poorly reasoned. The fact that the miner was treated with various medications and inhalers during the 1980's and 1990's suggests that those treating physicians believed that the miner suffered from a *treatable* lung disease, *not* an irreversible one such as pneumoconiosis. Finally, I note that Dr. McMonagle is Board-certified in Internal Medicine, he is neither a pulmonologist nor a pathologist. In view of all of the foregoing, I accord lesser weight to Dr. McMonagle's opinion despite his status as one of the miner's treating physicians.

I have also carefully weighed the conflicting medical opinions of Drs. Green and Perper, who are both well-credentialed Board-certified pathologists. Based upon my analysis of the foregoing opinions, in conjunction with other relevant evidence, I find the opinion of Dr. Perper is

more persuasive than that of Dr. Green regarding the "death due to pneumoconiosis" issue.

In making this determination, I find that Dr. Perper's opinions is more consistent with the credible objective medical evidence. As stated in the Decision and Order of Judge Morin, in 1984, which was affirmed by the Board in 1987, the early medical opinion evidence failed to establish the presence of pneumoconiosis and/or a totally disabling respiratory or pulmonary impairment (DX 1). Similarly, in 1989, the District Director found that the medical evidence developed in 1988 and 1989 did not establish a material change in conditions (DX 2). Accordingly, as of 1989, the miner had failed to establish any of the elements of entitlement; and, his claims were finally denied.

In view of the progressive, latent, and irreversible nature of pneumoconiosis, however, and the fact that the miner died more than 10 years after the denial of the second miner's claim, my primary focus is on the more recent medical data, which clearly establishes the presence of simple pneumoconiosis by autopsy. However, I have carefully considered the clinical test results, as set forth in the hospital records, and find that they also do not support the opinions of Dr. Green or Dr. McMonagle regarding the severity of the miner's respiratory or pulmonary impairment and/or its role in the miner's death. As set forth above, the miner was seen by Dr. Powell, a pulmonary consultant, in January 1999 (*i.e.*, almost 19 years after Mr. Frameli left the coal mines and only slightly more than a year prior to his death). At that time, Dr. Powell reported that although the miner was hypoxemic on admission with a pO2 of 55, there was subsequent improvement with treatment and the pO2 rose to the 80s. It is well settled that such an improvement is inconsistent with the progressive and irreversible nature of pneumoconiosis. Moreover, in January 1999, Dr. Powell also reported essentially normal pulmonary function results, except for a reduced peak flow rate and MVV, despite suboptimal effort. In addition, Dr. Celko reported in the Discharge Summary, dated December 17, 1999 (*i.e.*, approximately two months prior to the miner's death), the following, clearly, nonqualifying blood gas results: pCO2-28, pO2-91 (DX 13). Furthermore, as discussed above, the autopsy report supports Dr. Perper's finding of only "mild" pneumoconiosis, and emphasizes the miner's many other health problems immediately prior to his death (DX 11). Accordingly, I find that Claimant has failed to meet her burden of establishing death due to pneumoconiosis under §718.205(c), or by any other means.

Conclusion

Although the evidence shows that the miner had simple pneumoconiosis which arose from his 35-plus years of coal mine employment, it does not establish that pneumoconiosis caused, substantially contributed to, or hastened the miner's death. Therefore, I find that the Claimant is not entitled to benefits under the Act and applicable regulations.

Attorney's Fees

The award of an attorney's fee under the Act is permitted only in the cases in which Claimant is found to be entitled to benefits. Since benefits are not awarded in this case, the Act

prohibits the charging of any fee to the claimant for services rendered to him in pursuit of this claim.

ORDER

It is ordered that the claim of Isabelle P. Frameli, surviving spouse of Joseph A. Frameli, for black lung benefits under the Act is hereby **DENIED**.

A

RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal to the Benefits Review Board within 30 days from the date ofthis Decision and Order, by filing a notice of appeal with the **Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601.** A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room –2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.